



For Office Use Only

Date of Receipt & Staff Initials: _____ Referral Source: _____

Notes: _____

Individual Transitional Living Program Application

****Please be sure to review the Ithaka program overview before filling out this application****

Exclusion Criteria

- I cannot have any active warrants.
- I cannot be a Sexually Violent Predator (SVP), not to be confused with a Sex Offender.
- I cannot enter the program if I haven't been compliant with the terms of my probation or parole.
- I cannot be experiencing withdrawal from any drugs, including alcohol.
- I can physically care for myself and am able-bodied.

Program Expectations & Policy

- I understand that I will need to pay \$100.00 towards first month's rent prior to moving in or utilize Housing Vouchers provided by the Department of Corrections (DOC).
- I understand that I must be over the age of eighteen.
- I understand that I must provide a UA (and potential BA) upon entry into the program with a negative outcome and am also subject to random UA's at staff's discretion.
- I understand that there is no drug use or alcohol use within the program and may be cause for an immediate discharge from the program. I also understand that this applies to the use of marijuana.
- I understand that the program has a strict (2) year cut off time.
- I understand that I must be engaged full-time in the program and meet with the Director of Case Management when requested.
- I understand that I will follow the program guidelines, explained to me in detail by the Director of Case Management.
- I understand that my room will be inspected on a regular basis.
- I understand that any violence, destruction of property, illegal activities (and other violations) can and will result in an immediate exit from the program.
- I understand that violations of any stated rules will result in an infraction, and should I obtain a total of (3) infractions I will be terminated from the program. I can also be terminated from the program with only (1) infraction depending on the severity of the infraction.
- I understand that no gang affiliated clothing (or signs of affiliation) is allowed in the program.
- I understand that there is ABSOLUTELY NO SMOKING of any kind inside the premises. This includes cigarettes, marijuana (or other drugs), vapes, candles, and incense. Doing so will result in an immediate discharge from the program.
- I understand that that I will need to sign a set of "Release of Information" (ROI) forms for a variety in entities to include judicial (probation/parole), mental and physical health, and any other requested ROI's. The Director of Case Management will explain this in more detail upon entry into the program.
- I understand that no pets are allowed in the program.
- I understand that the following items are band from the premises to include drugs (aside from prescribed medication), alcohol, pornography / erotica, fireworks, weapons, knives, candles, or any other contraband deemed unsafe by staff.

APPLICANT INFORMATION

Name _____ Alias: _____

Mailing Address: _____

Phone: () _____ Can we text you? _____ Can we leave voice mail? _____

Email: _____

Date of Birth: _____ Gender: _____ Preferred Pronouns: _____

Social Security # _ _ _ - _ _ - _ _ _ _ _

Hispanic/Latino: Yes No Race: _____ Highest Education Completed: _____

Are you a veteran? Yes No Dates of Service: _____ Branch: _____

Theater of operations: _____ Discharge Status: _____

Have you applied to Ithaka Housing before? Yes No

If yes, please describe: _____

Driver's License or Colorado ID (if any):

Your Driver's License Number: _____ State: _____

Vehicle Information:

Make/Model: _____ Year: _____ License Plate State: _____

Please describe your current living situation in as much detail as possible:

CRIMINAL BACKGROUND INFORMATION

Have you ever been charged with a misdemeanor or felony? Yes No

If yes, please describe each charge, the date(s) of the charge(s), and the situation (who, what, where, when) in as much detail as possible:

IF YOU ARE INCARCERATED, THIS SECTION IS ABSOLUTELY REQUIRED. YOU MUST ALSO LIST A CASE MANAGER AND CONTACT INFORMATION FOR YOUR CASE MANAGER ON THE RELEASE OF INFORMATION PAGE.

Are you on a tabled status with Parole? _____

If yes, when will your tabled status expire? _____

Upon release, will you be required to register as a **Sexually Violent Predator**? _____

*Again, this is different than a registered sex offender status.

Will you be released on a Mandatory Release date? _____ What is that date? _____

Is there anything else that we should know to work with your Case Manager and Parole?

Are you currently involved in any court/legal proceedings?

Yes

No

If yes, please explain:

SUBSTANCE ABUSE HISTORY:

When was the last time you had something alcoholic to drink? _____

How much do you drink at one time? _____

How many times did you drink last month? _____

Has your drinking caused any problems for you? [] yes [] no

Please Explain: _____

Have you ever been in an alcohol treatment program? [] yes [] no

If Yes, When and Where:

Have you ever used drugs? [] yes [] no

If Yes, When and What: _____

When was the last time you used drugs? _____

Have you ever been in a drug treatment program? [] yes [] no

If Yes, When and Where:

HEALTH & MENTAL HEALTH HISTORY:

Have you ever received treatment or care for an emotional problem or mental disorder? yes no
If yes, please list the diagnoses:

Who is your mental health provider and when did you begin seeing them:

Have you ever been prescribed medications for mental, emotional, or behavioral concerns? yes no

If yes, please list:

Name(s) of medication(s):

When did you start taking your medication(s)? Do you take your medication(s) as prescribed?

Have you survived domestic violence?

Yes

No

When did this occur? _____

Are you disabled? Physical

Developmental

None

If yes, please describe: _____

Do you have a chronic health condition?

Yes

No

If yes, does/will this affect your ability to live independently?

Yes

No

INCOME INFORMATION:

Are you willing and able to work in a full-time position?

Yes

No

Are there any limitations on your ability to work? Yes

No

If yes, please describe those limitations:

Current Employment Status: Full-Time Part-Time Unemployed

If you are currently employed, please list your employer, start date, and a contact number:

If you marked 'Unemployed', please describe your prior work history in detail. When was the last time you were employed? What work have you done in the past? Have you been job searching? If you have, how long have you been job searching? What barriers are you facing to employment?

Income Sources (complete all that apply)

Employment	\$ _____ /month
	Source: _____
Unemployment Insurance	\$ _____ /month
Supplemental Security Income (SSI)	\$ _____ /month
Social Security Disability Income (SSDI)	\$ _____ /month
VA Service-Connected Disability Compensation	\$ _____ /month
VA Non-Service-Connected Disability Pension	\$ _____ /month
Private Disability Insurance	\$ _____ /month
Worker's Compensation	\$ _____ /month
Temporary Assistance for Needy Families (TANF)	\$ _____ /month
General Assistance (GA)	\$ _____ /month
Retirement Income from Social Security	\$ _____ /month
Pension or Retirement Income from a former job	\$ _____ /month
Child Support	\$ _____ /month
Alimony or other spousal support	\$ _____ /month
Other source	\$ _____ /month
Specify source _____	
Total Monthly Income	\$ _____

Non-Cash benefits

<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) \$ _____	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/> TANF Child Care services	<input type="checkbox"/> Other TANF-funded services
<input type="checkbox"/> TANF transportation services	<input type="checkbox"/> Other _____

Health Insurance (all clients)

<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> Medicare _____	<input type="checkbox"/> VA Medical Services
<input type="checkbox"/> State Children's _____	<input type="checkbox"/> Employer-Provided	<input type="checkbox"/> State Health Insurance for Adults
<input type="checkbox"/> Private Pay	<input type="checkbox"/> COBRA	<input type="checkbox"/> Indian health service program
<input type="checkbox"/> Other _____	<input type="checkbox"/> None	

REFERENCES

Personal Reference or Emergency Contact:

Name _____ Address _____

Phone _____ Relationship _____

Email Address _____

Professional Reference

Name _____ Address _____

Phone _____ Relationship _____

Email Address _____

Parole/Probation Officer or Case Manager:

Name: _____ Organization: _____

Phone: _____ Ext: _____ Title: _____

Email Address _____

Mental Health Counselor:

Name: _____ Organization: _____

Phone: _____

Email Address _____

I understand that this is a preliminary application and the information provided does not guarantee housing. I certify that all information contained herein is true and correct to the best of my knowledge.

It is the policy of Ithaka to accept applications and place applicants into housing units based on need and date of application. In compliance with local, state, and federal laws, we provide housing regardless to applicants regardless of race, color, national origin, sexual orientation, age, gender identity, disability, or veteran status. In addition, policies that affect current residents will be carried out without regard for these irrelevant factors.

I authorize an investigation of my credit, tenant history, criminal history and employment for the purposes of renting a house, apartment or room from Ithaka Land, Inc. Applicant hereby authorizes Ithaka Land, Inc, its employees and agents to verify said information and make independent investigations in person, by mail, telephone, fax, or otherwise, to determine Applicant's rental, credit, financial, criminal and character standing. Applicant hereby releases Ithaka Land, Inc., its employees and agents, First American Registry, Inc., its employees and agents and any and all other firms or persons investigating or supplying information, for any liability whatsoever concerning the release and/or use of said information and further, will defend and hold them all harmless from any suit or reprisal whatsoever. A copy, fax or other reproduction of this Authorization shall be as effective as the original.

Name (please print)

Date

Signature

REV: 03/22/26 SB

**AUTHORIZATION FOR USE/DISCLOSURE/OBTAINMENT
OF HEALTH/SERVICES INFORMATION**

Authorization for Use/Disclosure/Obtainment of Information: I voluntarily consent authorizing Ithaka Housing to use, disclose, or obtain records or knowledge of me or my treatment during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my information to be released to and/or obtained from the following recipient(s):

Title: Parole Officer / Probation Officer / Case Manager / Re-Entry Coordinator

Name & Title: _____

Phone: _____

Purpose: I authorize the release/obtainment of my information for the specific purpose of application, interview, housing, or care coordination.

Information to be disclosed: I authorize the release/obtainment of the following information: (check the applicable box below)

- All information pertaining to Ithaka's application process and transitional living program, including information relating to any medical or mental health history, mental or physical condition, substance use progress, behavior, program adherence, and any treatment received by me.

Term: I understand that this authorization will remain in effect until I end my residency in the Ithaka Housing Transitional Living Program.

Redisclosure: I understand that Ithaka Housing cannot guarantee that the recipient will not redisclose my information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my information.

